

Camper Health Form

Camper's Name _____ Which camp attending? _____

Medical Information

Operations or serious injuries _____

Penicillin or other drug reactions _____

Ever had a bee sting? _____ If so, reaction _____

Food or other allergies _____

Special Diet _____

Medications being taken _____

(All Prescription medications should be in original containers clearly marked with the physician's instructions.)

In case of an emergency I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the physician selected by the camp director to secure proper treatment for my child including hospitalization and/or surgery.

I give my permission for Camp Health personnel to administer non-prescription medications listed in the Camp Doctor's standing orders in the event of a minor illness.

Parent's Signature _____ Date _____

Date of last immunization:

DPT or DT _____ MMR _____ TETANUS _____

PHYSICIAN'S SECTION

I have examined this camper and found him/her to be in satisfactory condition, free from contagious disease, and capable of active participation at 10,000 ft for one week in a regular camping program except as follows: _____

Physician's Signature _____ Date _____

Address _____ City _____ State ____ Zip _____

Phone _____

Medical Insurance _____ Policy # _____ Phone _____

Address _____

Assignment benefits (Signature of family member insured): _____

Doctor's name and phone # _____

Dentist's name and phone # _____

Camp nurse _____